TGH Tampa General Hospital®

TAMPA GENERAL HOSPITAL
IMPLEMENTATION STRATEGY PLAN

CITRUS COUNTY

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INTRODUCTION

Tampa General Hospital (TGH) Crystal River is committed to improving the health and well-being of residents in its service area, which includes Citrus County. As a not-for-profit hospital, TGH Crystal River conducts a Community Health Needs Assessment (CHNA) every three years, as required by Section 501(r)(3) of the Internal Revenue Code. This CHNA identifies the most pressing health needs in the community and helps guide the hospital's efforts to address them.

The CHNA process includes input from a broad range of community members, including public health experts and representatives of under-resourced populations. This collaborative approach ensures that the assessment reflects diverse perspectives and community experiences.

The findings in the CHNA report informed this hospital implementation strategy plan, which outlines specific strategic actions TGH Crystal River will take to address identified health needs. The CHNA and hospital implementation strategy plan were approved by the TGH Crystal River Board of Directors on August 19, 2025. The documents are made publicly available to ensure transparency and accountability.

About Tampa General Hospital Crystal River

Since 1978, TGH Crystal River has served Citrus County residents with a commitment to creating lasting patient relationships and providing safe care across our entire community.

Offering specialized care in orthopaedics, cardiology, urology, general and vascular surgery, robotic-assisted surgery, gynecologic and bariatric surgeries, and more, our 128-bed acute care hospital is accredited by The Joint Commission and serves as a comprehensive health care solution for patients in the Crystal River community.

Enhancing health outcomes in the community and prioritizing our patients' well-being is at the heart of everything we do, as demonstrated by our Chest Pain Center Accreditation from the American College of Cardiology (ACC) Accreditation Services, certification as a Primary Stroke Center by The Joint Commission and designation as a Center of Excellence in Orthopedic Surgery by Surgical Review Corporation (SRC).

For more information, visit the TGH Crystal River website at https://www.tghnorth.org/locations/tampa-general-hospital-crystal-river.

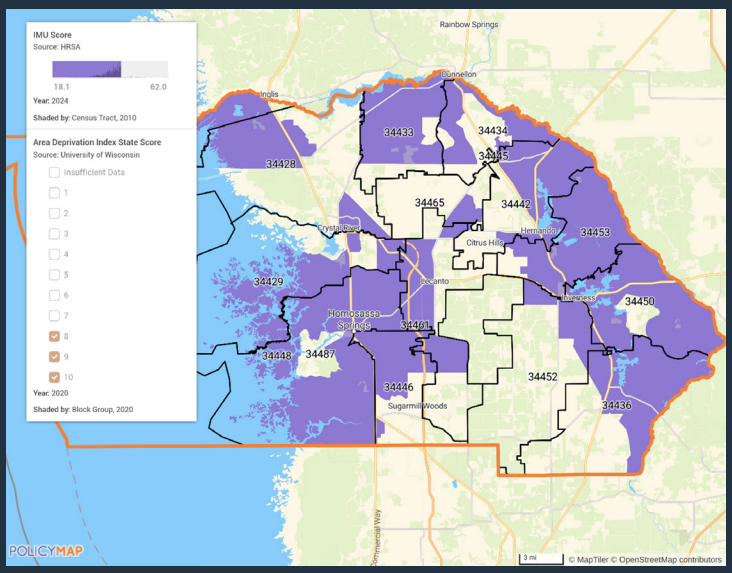
Service area

The TGH Crystal River CHNA service area is Citrus County. However, TGH Crystal River targets its efforts in the highest-need zip codes in the county.

Highest-need zip codes

The following zip codes have the highest need in Citrus County based on the Index of Medical Underservice (IMU)[1] and Area Deprivation Index (ADI)[2].

Highest-Need Zip Code	Geographic Location
34453	Inverness
34450	Inverness
34487	Homosassa
34433	Citrus Springs



1. Represents areas of highest need by census tract, using the following criteria: Ratio of primary care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, percentage of the population aged 65 or over, and areas of the highest need have a score between 0 and 62. The lower the score the higher the need. Source: Health Resources and Services Administration (HRSA).

2. ADI ranks neighborhoods (census blocks) based on socioeconomic disadvantage, using the following criteria: Income, education, employment and housing quality. Census blocks are scored from 1 to 10. Higher ADI scores have been shown to correlate with worse health outcomes. Source: Center for Health Disparities Research at University of Wisconsin School of Medicine and Public Health.

COMMUNITY HEALTH NEEDS ASSESSMENT OVERVIEW

TGH Crystal River participated in the All4HealthFL Collaborative Community Health Needs Assessment. Established in 2019, the All4HealthFL Collaborative is a partnership between seven not-for-profit health systems and four county departments of the Florida Department of Health in West Central Florida. The collaborative has a mutual interest in improving health by leading regional, outcome-driven health initiatives that have been prioritized through community health assessments.

A mixed-methods approach consisting of a combination of primary and secondary quantitative and qualitative research methods designed to evaluate the perspectives and opinions of community stakeholders, especially those from underserved and vulnerable populations, was implemented between September 2024 and February 2025.

Intentional outreach was made to vulnerable populations in the community, such as people of color, persons experiencing homelessness, persons living with behavioral health conditions, caregivers and young families. Focus groups and surveys were available in multiple languages to ensure that community residents were able to participate in the process in their language of choice.

Each activity is described below in more detail.

Secondary data provided a critical insight into the demographics of Citrus County, social drivers of health and behavioral health-related measures, among many others. The data was mainly collected from the U.S. Census Bureau American Community Survey, United States Centers for Disease Control and Prevention, and FLHealthCHARTS.

Qualitative research included seven one-on-one stakeholder interviews and one focus group with five participants, and seven intercept interviews. The primary qualitative data was collected between September 2024 and February 2025 in person and virtually. Please note that there were many crossover participants between Hernando and Citrus counties.

A **community survey** was conducted via SurveyMonkey and paper copies in English, Spanish, Haitian Creole, Russian and Vietnamese to evaluate and address health care, housing, employment, and other needs, gaps and resources in the community. A total of 241 responses were collected and analyzed. Survey responses are provided for Citrus County in this report.

The **needs prioritization process** was conducted on March 13, 2025, with 39 community partners and All4HealthFL Collaborative members. The meeting consisted of a data presentation, a discussion of data, community needs and potential strategies. A survey using a modified Hanlon Method was employed to prioritize the needs based on magnitude, severity and feasibility of addressing the need in each county.

Community needs

Seven community needs were identified for Citrus County. After a community-wide needs prioritization process utilizing a modified Hanlon Method, the following top three community priority areas were chosen for Citrus County.

Behavioral Health (Mental Health and Substance Misuse)

Health Care Quality and Access

Exercise, Nutrition and Weight

The following section contains key high-level findings for each of the top three priority areas.

PRIORITY AREA: BEHAVIORAL HEALTH

Key findings

Adults Self-Reported Poor Mental Health

15.1%

Adults Who Binge Drink

13.5%

0% 50% 100%

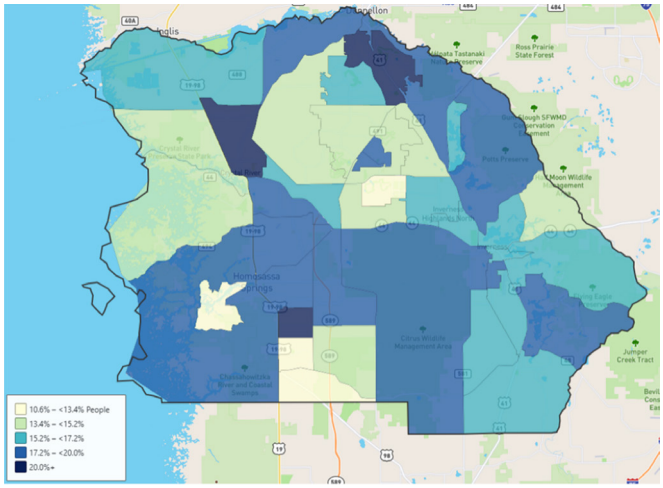
1,478:1 Mental Health Provider Ratio (People per Provider)

33.7 Suicide Rate, 2021-2023 (per 100,000 People)

1,196.9 Emergency Department Visits for Mental Health Conditions, 2021-2023 (per 100,000 people)

For more data, please visit the 2025 Community Health Needs Assessment

Poor Mental Health Among Adults, 2022



Source: CDC, n.d. BRFSS Places, 2022.

Key qualitative findings

> **"The fear in people, asking for help. They wait too long. My sister waits for a while. She is afraid to speak or ask for help. They are the ones that need the help."**
>
> **— Focus Group Participant**

Additional Themes Identified
Shortage of providers, especially for prevention and post-crisis care
Transportation to appointments
Ability to pay, including insurance barriers
Long wait lists for substance use care
Stigma

Community survey

17.4% **Adults Needed Mental Health Care in the Past 12 Months, but Did Not Receive It**

Top Reasons for Not Receiving Care
Unable to afford to pay for care
Unable to schedule an appointment when needed
Doctor or counselor office does not have convenient hours

PRIORITY AREA: HEALTH CARE QUALITY AND ACCESS

Key findings

Total Population Without Health Insurance

11.3%

Adults Who Received an Annual Medical Checkup in 2022

81.0%

0% 50% 100%

995:1 Primary Care Physician Ratio (People per Provider)

7,917:1 OBGYN Provider Ratio (People per Provider)

Births with Prenatal Care in the First Trimester

White

60.9%

Black

50.3%

Hispanic

58.1%

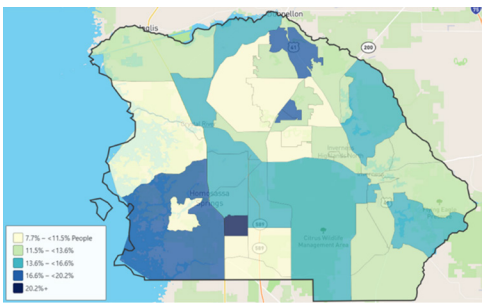
Non-Hispanic

60.8%

0% 50% 100%

For more data, please visit the 2025 Community Health Needs Assessment

Lack of Health Insurance Among Adults, 2022



Source: CDC, n.d. BRFSS Places, 2022.

Key qualitative findings

> **"With only two hospitals and the influx of the people, the hospitals are a lot busier."**
>
> **— Focus Group Participant**

Additional Themes Identified
Knowledge and awareness of services
System navigation
Availability of providers, especially specialists
Transportation to appointments
Ability to pay, including insurance barriers
Health literacy

Community survey

25.0% **Adults Needed Mental Health Care in the Past 12 Months, but Did Not Receive It**

Top Reasons for Not Receiving Care
Unable to afford to pay for care
Unable to schedule an appointment when needed
Cannot take time off work

PRIORITY AREA: EXERCISE, NUTRITION AND WEIGHT

Key findings

Total Food Insecurity

16.5%

Child Food Insecurity

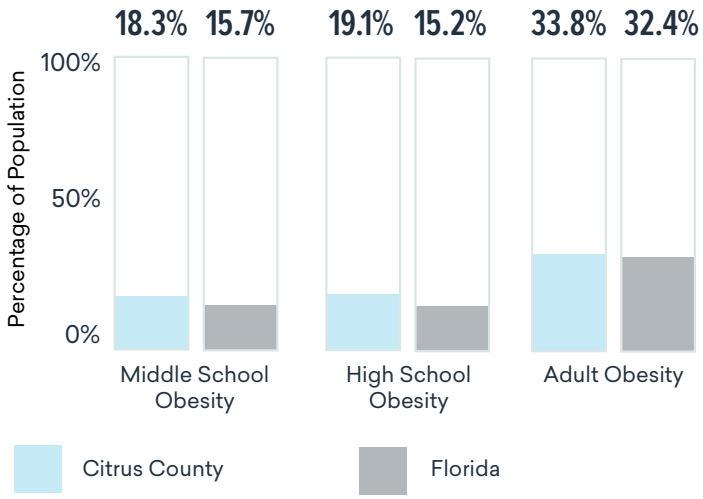
22.3%

Elementary School Students Eligible for Free or Reduced Price Lunch

68.6%

For more data, please visit the 2025 Community Health Needs Assessment

Adolescent and Adult Obesity, 2022



Source: FLHealthCHARTS, 2022.

One in three adults is obese in Citrus County.

Key qualitative findings

> **"Food is so expensive that people are buying food that fills them up longer but aren't nutrient dense. Some people are low in iron so, they buy supplements, but then still aren't getting the right nutrients."**
>
> **— Stakeholder Interview**

Additional Themes Identified
Food insecurity
Increased food costs and inflation

Community survey

30.9% **Respondents Reported Experiencing Food Insecurity**

Food insecurity was **highest** in the lowest-income brackets.

IMPLEMENTATION STRATEGY PLAN METHODOLOGY

TGH Crystal River developed this implementation strategy plan through a structured, multi-phase process that integrated data analysis, evidence-based research and stakeholder engagement to identify and address community health priorities.

Prioritization of community health needs

An in-person county needs prioritization session was conducted with TGH Crystal River staff and community partners from throughout Citrus County. During the session, participants used a modified Hanlon Method approach[3] to discuss and prioritize community needs.

Following this structured process, the top needs were ranked in the following order:

Rank	Community Need	Score
1	Behavioral Health	8.40
2	Health Care Quality and Access	9.21
3	Economic Stability	12.41
4	Heart Disease and Stroke	12.46
5	Exercise, Nutrition and Weight	14.73
6	Neighborhood and Built Environment	15.61
7	Cancer	16.51

3. The Hanlon Method is an evidence-based approach approved by the National Association of County and City Health Officials (NACCHO). Source: National Association of County and City Health Officials (2023) Guide to Prioritization Techniques. https://www.naccho.org/uploads/downloadable-resources/Gudie-to-Prioritization-Techniques.pdf

Development of strategies and actions

Development of strategy options

To formulate effective strategies for prioritized health needs, TGH Crystal River undertook the following steps

- **Best practices literature review:** Conducted a comprehensive review of current best practices and evidence-based interventions related to behavioral health; exercise, nutrition and weight; and health care quality and access.
- **Review of existing hospital programs:** Assessed current TGH Crystal River programs and initiatives addressing the identified needs to pinpoint opportunities for enhancement and alignment with best practices.
- **Identify partnerships:** TGH Crystal River reviewed opportunities to partner with local nonprofit organizations working on similar initiatives to reduce duplication in the community.

Definition of terms

To ensure clarity and consistency throughout the implementation strategy plan (ISP), the following terms are defined. These terms describe how the hospital organized its approach to addressing community health needs, setting goals, and identifying strategies and actions for the 2025-2028 planning cycle.

Term	Definition
Priority Areas	**Selected community health needs for the 2025-2028 ISP**
Goal	**Future desired result of each priority area, written as a SMART goal statement**
Objective	**What the hospital is doing to reach the priority area goal**
Action	**Approximately 1-5 for each objective, though not all objectives may have actions**
Initiative	**Programs or initiatives offered by TGH Crystal River or community partners**

Hospital response to top regional needs

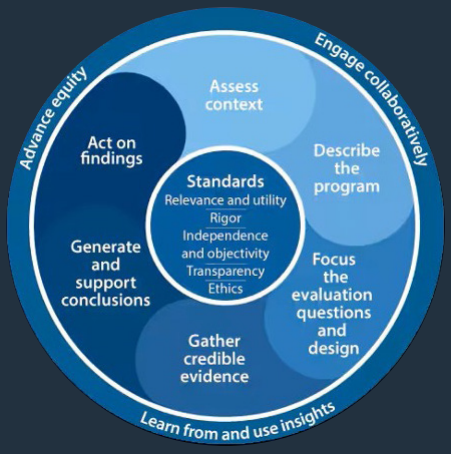
Health Need Identified by Community in CHNA	Hospital's Response
Behavioral Health	This category has been identified as a priority health need. See page 15 for our plan to address it.
Health Care Quality and Access	This category has been identified as a priority health need. See page 17 for our plan to address it.
Economic Stability	This category has been identified as a priority health need. It will be intertwined with the other three priority health needs.
Heart Disease and Stroke	This category has been identified as a priority health need, and it has been included with exercise, nutrition and weight.
Exercise, Nutrition and Weight	This category has been identified as a priority health need. See page 18 for our plan to address it.
Neighborhood and Built Environment	TGH Crystal River did not identify this category as a priority health need but will continue providing patients with referrals to local nonprofit organizations that provide services to address this category.
Cancer	TGH Crystal River did not identify this category as a priority health need but will continue providing cancer care at the TGH Cancer Institute.

Evaluation plan

Evaluation of any implementation strategy plan (ISP) is just as critical as the implementation of strategies, programs and initiatives. To measure the progress of goals, TGH Crystal River will utilize the Centers for Disease Control and Prevention (CDC) Program Evaluation Framework (2024). The three foundational principles of this framework are engaged collaboratively, advance equity, and learn from and use insights.

The framework includes six steps to complete a successful evaluation:

1. Assess the context
2. Describe the program
3. Focus the evaluation questions and design
4. Gather credible evidence
5. Generate and support conclusions
6. Act on findings



TGH Crystal River will evaluate the progress on each goal on an annual basis. Starting at Year 0, TGH Crystal River will determine the baseline for each goal. Each year after Year 0, the progress will be measured against the baseline. Whenever possible, TGH Crystal River will use local, state and national benchmarks, such as Healthy People 2030 or County Health Rankings, as additional benchmarks to measure against each year.

The evaluation of the ISP should include both quantitative and qualitative assessments, as not every goal can be successfully measured quantitatively. It is important to learn qualitative findings, such as the human stories behind each goal.

IMPLEMENTATION STRATEGY PLAN SUMMARY

The summary outlines TGH Crystal River's comprehensive health improvement plan focused on behavioral health; exercise, nutrition and weight; and health care quality and access, aiming for measurable progress in Citrus County by 2028.

- **Behavioral health improvement goal:** Enhance mental health awareness, reduce stigma and decrease substance misuse among adults and youth through training, education, screenings and community collaboration.
- **Training and education initiatives:** Implement and expand evidence-based programs — such as Mental Health First Aid; Tools to Quit; and Question, Persuade, and Refer (QPR) — to equip providers and community members.
- **Community partnerships and services:** Collaborate with local organizations to provide behavioral health screenings, mobile and telehealth services, and harm-reduction programs, including needle exchange and nutrition education.
- **Social and economic investments in behavioral health:** Support nonprofits and community partners with financial resources, sponsorships and provider recruitment to enhance behavioral health and substance misuse services.
- **Exercise, nutrition and weight goal:** Address food insecurity, heart health and physical activity by developing policies, referral systems and community programs focused on built environment and health disparities.
- **Community-based health initiatives:** Promote physical activity, nutrition education, cooking classes and access to healthy foods through partnerships with organizations like YMCA, Feeding Tampa Bay and the American Heart Association.
- **Support for health conditions:** Implement disease-specific self-management programs and evidence-based interventions targeting heart disease, stroke and related social determinants of health.
- **Health care quality and access goal:** Enhance connection to quality health and social services through increased access points, health literacy education, navigation services and coordinated referral platforms.
- **Investment in health care programs:** Provide financial support and recruit health care providers to reduce disparities and systemic barriers, collaborating with entities such as the University of South Florida and social service organizations.

Priority area 1: Behavioral health (including substance use)

Goal: To improve mental health awareness, and reduce stigma and substance misuse in adults and youth in service areas by 2028 in Citrus County.

	Actions	Initiatives	Dedicated Resources	Potential Partners
Objective 1	**Equip service providers and community members with training to develop the knowledge and skills needed to identify and respond to behavioral health concerns in their specific communities.**			
Action 1.1	Implement evidence-based training and education programs.	• Mental Health First Aid (MHFA) • Tools to Quit & Quit Smoking Now	• Human and financial resources • Tools, technology and physical materials • Space	Directions for Living, Citrus County Department of Health, Tobacco Free Florida, University of South Florida AHEC, Gulf Coast North AHEC
Action 1.2	Expand the reach of existing evidence-based interventions and education programs	• Instructor training • Community partner collaboration	• Human and financial resources • Tools, technology and physical materials • Space	All4Health Florida, Directions for Living, Citrus County Department of Health, Tobacco Free Florida, University of South Florida AHEC, Gulf Coast North AHEC
Action 1.3	Collaborate with community partners to support behavioral health initiatives.	• Youth & Teen Mental Health First Aid • Tools to Quit & Quit Smoking Now • Question, Persuade, and Refer (QPR)	• Human and financial resources • Tools, technology and physical materials • Space	All4Health Florida, Directions for Living, Citrus County Department of Health, Tobacco Free Florida, University of South Florida AHEC, Gulf Coast North AHEC
Action 1.4	Provide behavioral health screenings, education and related services to the community.	• Mobile and telehealth services • Community workshops • Navigation and referral services • TAVA	• Human and financial resources • Tools, technology and physical materials • Space	Directions for Living, Citrus County Department of Health, Tobacco Free Florida, University of South Florida AHEC, Gulf Coast North AHEC
Action 1.5	Launch evidence-based programs that address identified concerns.	• Question, Persuade, and Refer (QPR workshops • Other behavioral health interventions	• Human and financial resources • Tools, technology and physical materials • Space	QPR Institute, Directions for Living, Citrus County Department of Health, University of South Florida

Chart continues on following page.

	Actions	Initiatives	Dedicated Resources	Potential Partners
Objective 2	**Reduce stigma by increasing access to education, awareness, training and navigation to equitable behavioral health services.**			
Action 2.1	Implement evidence-based training and education programs.	• Mental Health First Aid • Tools to Quit & Quit Smoking Now • Question, Persuade, and Refer (QPR)	• Human and financial resources • Tools, technology and physical materials • Space	University of South Florida, CAN Community Health, The Salvation Army, Metropolitan Ministries
Action 2.2	Collaborate with community partners to support behavioral health initiatives.	• Youth & Teen Mental Health First Aid • Tools to Quit & Quit Smoking Now • Question, Persuade, and Refer (QPR)	• Human and financial resources • Tools, technology and physical materials	All4Health Florida, QPR Institute, Directions for Living, Citrus County Department of Health, Tobacco Free Florida, University of South Florida AHEC, Gulf Coast North AHEC, QPR Institute, Independent Community Provider Practices
Action 2.3	Provide services through the Coordinated Regional Harm Reduction Continuum (CRHRC) and Street Medicine Program.	• Needle exchange program • Wound care services • Nutrition education • STI education	• Human and financial resources • Tools, technology and physical materials • Space	University of South Florida, CAN Community Health, The Salvation Army, WellFed, Feeding Tampa Bay
Action 2.4	Provide behavioral health screenings, education and related services to the community.	• Mobile and telehealth services • Community workshops • Navigation and referral services • TAVA	• Human and financial resources • Tools, technology and physical materials • Space	University of South Florida, CAN Community Health, The Salvation Army, Citrus County Department of Health, Faith-based Community Partners
Objective 3	**Increase social and economic investments in the community.**			
Action 3.1	Provide financial support and resources to nonprofit organizations and community partners focused on the expansion and enhancement of behavioral health and substance misuse prevention, education, treatment, and recovery services.	• Sponsorship funding • Health professions education • Provider recruitment	• Cash & in-kind donations • Clinical rotation & training site • Tools and technology, human resources, physical materials • Space	University of South Florida, Citrus County Department of Health, The No More Foundation, NAMI, Independent Community Provider Practices

Priority area 2: Health care quality and access

Goal: Promote and support services that connect individuals with quality health and social programs in Citrus County by 2028.

	Actions	Initiatives	Dedicated Resources	Potential Partners
Objective 1	**Provide social services, health literacy education and navigation services that address social determinants of health (SDoH).**			
Action 1.1	Increase health care access points.	• Telehealth & mobile services • Health professions education • Provider recruitment	• Human and financial resources • Tools, technology and physical materials • Space	University of South Florida, Citrus County Department of Health, Independent Community Provider Practices
Action 1.2	Use SDoH platforms to connect individuals to programs and services.	• Unite Us • Find Help	• Human and financial resources • Tools, technology and physical materials	Unite Us, Find Help, Social Service and Community Organizations
Action 1.3	Provide support and social services to individuals impacted by SDoH.	• Marketplace enrollment • Navigation services • Community partnerships	• Human and financial resources • Tools, technology and physical materials	Senior Connection Center, Citrus County Department of Health, Social Service and Community Organizations
Action 1.4	Collaborate with community partners on initiatives and referral processes to organizations that address issues related to SDoH.	• Open enrollment education workshops • Health literacy education • Social service programs	• Human and financial resources • Tools, technology and physical materials • Space	Senior Connection, Citrus County Department of Health, Independent Community Provider Practices
Objective 2	**Increase health literacy and health navigation through education and awareness.**			
Action 2.1	Expand services and education to individuals.	• Telehealth & mobile services • Health literacy education • Social service programs	• Human and financial resources • Tools, technology and physical materials • Space	Social Service and Community Organizations
Action 2.2	Use SDoH platforms to connect individuals to programs and services.	• Unite Us • Find Help	• Human and financial resources • Tools, technology and physical materials	Unite Us, Find Help, Social Service and Community Organizations

Chart continues on following page.

Action 2.3	Collaborate with community partners on education and awareness campaigns that address health literacy and education on available social services in the community.	• Health literacy education • Social service programs	• Human and financial resources • Tools, technology and physical materials • Space	All4Health Florida, Unite Us, Find Help, Social Service and Community Organizations
Objective 3	**Increase social and economic investments in the community.**			
Action 3.1	Provide financial support and resources to community partners to support programs focused on health care quality and access and programs that eliminate disparities and systemic barriers to care.	• Sponsorships • Health professions education • Recruiting health care providers	• Sponsorships • Health professions education • Recruiting health care providers	University of South Florida, Social Service and Community Organizations

Priority area 3: Exercise, nutrition and weight (including heart disease and stroke)

Goal: Implement initiatives that address food insecurity, heart health and physical activity in Citrus County by 2028.

	Actions	Initiatives	Dedicated Resources	Potential Partners
Objective 1	**Develop and implement systems of change and policy that address social determinants of health (SDoH) initiatives related to exercise, nutrition and weight, including those that focus on heart disease and stroke.**			
Action 1.1	Implement a process to identify and refer individuals to programs and services related to economic development and stability.	• Food insecurity and SDoH screening for individuals	• Human and financial resources • Tools, technology and physical materials • Space	Social Service and Community Organizations, Feeding Tampa Bay
Action 1.2	Implement a referral process to evidence-based programs that address health conditions related to exercise, nutrition and weight, including those that focus on heart disease and stroke.	• Epic integration for referring individuals to programs	• Human and financial resources • Tools, technology and physical materials	Epic, YMCA, Feeding Tampa Bay, social service and community organizations

Chart continues on following page.

Objective 2	**Support local policies and programs that address the built environment and impact obesity, inadequate access to healthy food and physical activity disparities.**			
Action 2.1	Collaborate with community partners on initiatives related to the built environment, exercise, nutrition and weight, including those that focus on heart disease and stroke.	• Physical activity and nutrition education • Cooking classes • Opportunities to access healthy foods	• Human and financial resources • Tools, technology and physical materials • Space	All4Health Florida, YMCA, WellFed, University of South Florida, American Heart Association, Goodr, Feeding Tampa Bay, Citrus County Parks and Recreation, Independent Community Provider Practices
Action 2.2	Implement evidence-based programs that address health conditions related to exercise, nutrition and weight, including those that focus on heart disease and stroke.	• Disease-specific self-management programs • Physical activity, nutrition education	• Human and financial resources • Tools, technology and physical materials • Space	YMCA, WellFed, University of South Florida, American Heart Association
Action 2.3	Support initiatives that address the built environment and impact obesity, inadequate access to healthy food and physical activity disparities, including those that focus on heart disease and stroke.	• Food pantry • Community garden • Nutrition, disease-specific education	• Human and financial resources • Tools, technology and physical materials • Space	All4Health Florida, Tampa Well, YMCA, University of South Florida, Feeding Tampa Bay, Goodr, American Heart Association
Objective 3	**Increase social and economic investments in the community.**			
Action 3.1	Provide financial support and resources to nonprofit organizations and community partners focused on expansion and enhancement of programs and services that address the built environment and impact obesity, inadequate access to healthy food and physical activity disparities, and also address key risk factors for heart disease and stroke and related social and economic determinants of health.	• Sponsorship funding • Health professions education • Provider recruitment	• Human and financial resources • Tools, technology and physical materials • Space	YMCA, WellFed, University of South Florida, Girl Scouts of West Central Florida, Feeding Tampa Bay, American Heart Association, Independent Community Provider Practices

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